

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

admitted 10-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09373

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Joseph William Brooks

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 21, 1863 6.(c) If alive, give age _____ years

8. AGE: Years 84 Months 6 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Madison, Ind.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Mr. Joseph William Brooks
 13. Birthplace Madison, Ind.
 14. Maiden name Louise Taylor
 15. Birthplace Madison, Ind.

16. Informant Memorial Hospital recordsAddress Easton Md.

17. (Burial, cremation, or removal, Which?) Burial Date thereof 11/2/47
 (month) (day) (year)

Cemetery or crematory Old Trinity ChurchLocation Creech Creek, Md.18. Funeral director LeCompte Funeral ServiceAddress Cambridge Maryland

19. 10/31 19 47 N.A. Harrison
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-47 19 _____ at 3:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/12/1 19 47, to 10/31/1 19 47, and that I last saw him alive on 10/31/1 19 47.

Immediate cause of death _____

DURATION

Coronary occlusion 1 day

Due to _____

Arteriosclerosis, generalized ?

Due to _____

Other conditions Hypertrophied

Prostate
 (Include pregnancy within 3 months of death)

1 year

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE P.B. Cox M.D.

M. D. or other

Address Easton Md Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry C. Brunker4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary (Marie) G. Brunker7. Birth date of deceased (mo., day, yr.) December 29, 18878. AGE: Years 59 Months 9 Days 13 If less than one day9. Birthplace Salisbury, Maryland
(Town, county, and state)10. Usual occupation Electrician

11. Industry or business

12. Name Charles Brunker13. Birthplace Md.14. Maiden name Elizabeth Harrison15. Birthplace Md.16. Informant Mrs. Harry C. BrunkerAddress Salisbury, Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof October 14, 1947
(month) (day) (year)Cemetery or crematory Spring HillLocation Salisbury, Md.18. Funeral director Edwin BeckAddress Salisbury, Md.19. 10/13/47 N.H. Harrison
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 19 47, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 19 45 to 10/12/1947and that I last saw him alive on 10/12/1947

Immediate cause of death

Progressive spinal muscular atrophy

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

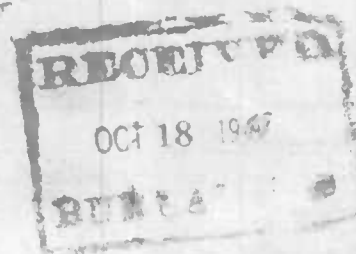
Means of injury

Injured at work?

23. SIGNATURE J.B. Cox M.D.

M. D. or other

Address Salisbury, Md. Date signed 10/13/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09375

Reg. Diat. No. 292

1. PLACE OF DEATH:

County Talbot
City or town Trappe (rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) Life
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Trappe (rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Alberta May Chase

3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Jan 16 - 1947

8. AGE: Years 8 Months 17 Days hrs. min.

9. Birthplace Trappe (rural) Talbot Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Joseph Chase
13. Birthplace Talbot Co Md

14. Maiden name Mary Scott

15. Birthplace Talbot Co Md

16. Informant Joseph Chase

Address Trappe Md RD

17. (Burial, cremation, or removal. Which?) Burial Date thereof Oct 4, 47
(month) (day) (year)

Cemetery or crematory Scott A ME

Location Trappe (rural)

18. Funeral director Eugene H. Bayne

Address Cambridge Md

19. Oct 22 19 47 Joseph Chase
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 19 47 at 11 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 19 47 to Oct 22 19 47
and that I last saw her alive on Dec 12 19 47

Immediate cause of death Acute enteric colitis DURATION 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Ct operations

Ct autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Chase M. D. or other

Address Trappe Md Date signed 10/31/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

RECEIVED

OCT 4 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09376

Reg. Dist. No. 292

1. PLACE OF DEATH:

County Talbot
 City or town Trappe
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? All of life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Talbot
 City or town Trappe
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 17
 (If rural, give LOCATION)
 2.(a) If veteran, name War

3. (a) FULL NAME

Lawrence B. Craig

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 23, 1884

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

63110hrs.min.

9. Birthplace

Talbot Co. Md

(Town, county, and state)

10. Usual occupation

Chief of Court (Dep.)

11. Industry or business

FATHER

12. Name

Barclay H. Craig

13. Birthplace

Talbot Co. Md.

14. Maiden name

Anna Kemp

15. Birthplace

Talbot Co. Md.

16. Informant

L. Kemp Haggett

Address

Trappe Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Oct 4, 1947

Cemetery or crematory

Spring Hill

Location

Trappe Md.

18. Funeral director

Maurice E. Leonard - Son

Address

Easton Md.

19.

(Date rec'd by registrar)

Oct 4, 1947

Registrar

Joseph A. Boos

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2, 1947 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 19, 42 to Oct 2, 47and that I last saw him alive on Oct 2, 47

Immediate cause of death

Valvular heart disease 2 yrs.Due to Arterio sclerosis andhypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

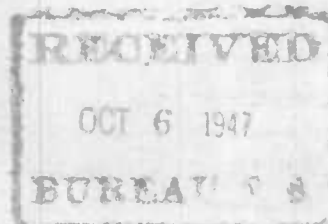
Injured at work?

23. SIGNATURE

Address

Date signed

William S. SeymourTrappe Md10-3-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69377

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: .
(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Georgia Rae Davis

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1922 6.(c) If alive, give age years

8. AGE: Years 24 Months 10 Days 27 If less than one day
 hrs. min.

9. Birthplace St. Michaels Talbot Co. Md.
 (Town, county, and state)

10. Usual occupation Dress maker

11. Industry or business

12. Name Levin Davis13. Birthplace Talsly, Va.14. Maiden name Lavinia Downs.15. Birthplace St. Michaels, Md.16. Informant Lavinia DavisAddress St. Michaels, Maryland

17. Burial Date thereof Oct 23, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory CemeteryLocation St. Michaels. Maryland18. Funeral director Newnam & HarrisonAddress St. Michaels, Md.

19. Oct 22 19 47 Mrs. R. H. Roberts
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18, 1947 19..... at 4:49 Pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1947 to Oct. 18, 1947
 and that I last saw him/her er alive on Oct. 18, 1947 19.....

Immediate cause of death Pulmonary tuberculosis

DURATION
2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy result None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of Oct 18, 1947

Where did injury occur? St. Michaels (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury St. Michaels Injured at work?

23. SIGNATURE Thelma B. Davis M. D. or other
St. Michaels Date signed 10.22.47

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OCT 23 1947

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09378

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... DorchesterCity or town... Preston Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 2 days

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 2 days

3. (a) FULL NAME

Fraser, Mr. William E.

4. Sex

m

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1875

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

71712

hrs.

min.

9. Birthplace

Canada

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

farmer

MOTHER FATHER

12. Name

Mr. William Fraser

13. Birthplace

Germany

14. Maiden name

Elizabeth Miller

15. Birthplace

Germany

16. Informant

Ernest Fraser

Address

Preston Md. R.D.

17.

(Burial, cremation, or removal) (which?)

Date thereof

10/12/47

(month) (day) (year)

Cemetery or crematory

Dorchester

Location

Preston Md.

18. Funeral director

J. G. Fraughton and Son

Address

Federalburg, Maryland

19.

(Date read by registrar)

19

47N. H. Meier

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Dorchester

City or town

Preston R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... 10 - 10 19 47, at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 8 19 47 to 10 Oct 19 47and that I last saw him alive on 9 Oct 19 47Immediate cause of death... Cardiac failure

DURATION

1 year

Due to

Arterio-sclerotic heart

Due to

dis ease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

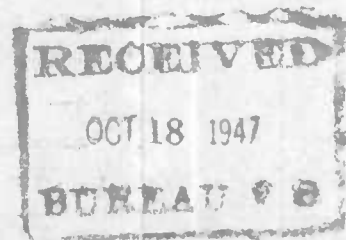
23. SIGNATURE

Thos. H. Harrison

M. D. or other

Address

Easton, MarylandDate signed 11 Oct 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09379
Reg. Dist. No. 290

1. PLACE OF DEATH:

County Sackett
 City or town Easton Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
Easton Memorial Hospital.
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent. g.a.
 City or town Greenville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Nick Gibbs (Simmons. Gibbs)

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male Black Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
52 _____ hrs. _____ min.9. Birthplace _____
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

14. Maiden name _____

15. Birthplace _____

16. Informant Memorial Hospital recordsAddress Easton Md.17. (Burial, cremation, or removal. Which?) Date thereof 10/20/47
(month) (day) (year)Cemetery or crematory GreenvilleLocation near Church Hill Md18. Funeral director Edgar L. LaneAddress Church Hill Md19. 10/19 47 N.H. Morris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 19 47 at 7 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Oct. 19 47 to 18 Oct 19 47and that I last saw him alive on 18 Oct 19 47Immediate cause of death Tuberculosis meningitis DURATION 5-6 days

Due to _____

Due to _____

Other conditions Tuberculosis meningitis
- hemiparesis
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

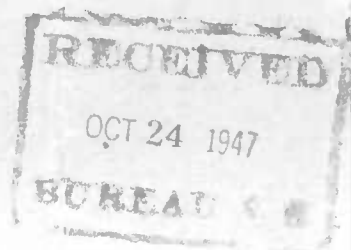
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thomas Harrison M.D.Address Easton Maryland Date signed 20 Oct 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 093844

1. PLACE OF DEATH:

County Talbot
 City or town Civilton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Civilton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah E. Pimmes

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife James L. Pimmes

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 Months 8 Days 23 If less than one day hrs. min.

9. Birthplace Civilton Talbot County Md.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own home

12. Name Hugh Haddaway

13. Birthplace Civilton Md.

14. Maiden name Rebecca Cummings

15. Birthplace Civilton Md.

16. Informant Rev. G. Brown Pimmes

Address Civilton Md.

17. Burial Date thereof Oct 7 - 47
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Civilton M. E.

Location Civilton Md.

18. Funeral director Norman Marshall

Address St. Michael's Md.

19. Oct 7 19 47 G. Jackson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 47 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from for 19 47 to Oct 7 19 47
 and that I last saw her alive on Oct 4 19 47

Immediate cause of death Cerebral pneumonia

Due to Osteia sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Reese M. D. or other

Address Civilton Md. Date signed Oct 7 1947

DURATION

2 x 2

10 yrs

RECEIVED

OCT 18 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton, md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 hours

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, md.How long in hospital or institution? 3 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. 189 Locust St.
(If rural, give LOCATION)2.(a) If veteran, name war veteran of world war I

3. (a) FULL NAME

Russell Poney

3. (b) Social Security Number

4. Sex

male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Pauline Poney7. Birth date of deceased (mo., day, yr.) January 6, 1896

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

5191

.....hrs.min.

9. Birthplace Talbot Co.
(Town, county, and state)10. Usual occupation Tailor

11. Industry or business

12. Name Joseph Poney13. Birthplace Unknown14. Maiden name Ella Johnson15. Birthplace Unknown16. Informant Hospital Records

Address

Easton, md.17. Burial Date thereof 10/10/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory RichardsLocation Easton, md.18. Funeral director Wm. H. HumesAddress 310 South St. Easton19. 10/18 47 N.A. Humes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 19 47, at 11 30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from death 19 47 to October 7 19 47 and that I last saw him alive on October 7 19 47Immediate cause of death Ischemic Carditis

DURATION

1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 6 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. Humes M. D. or otherAddress Easton, md. Date signed 10-7-47

RECEIVED

OCT 10 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09382

Reg. Diat. No. 291

1. PLACE OF DEATH:

County Talbot
City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Talbot
City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John B. Sands

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower
6.(b) Name of husband or wife Mamie B. Sands
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 20 1873
8. AGE: Years 74 Months 5 Days 26 If less than one day hrs. min.

9. Birthplace Hagerstown Md.
(Town, county, and state)
10. Usual occupation Machinist
11. Industry or business

FATHER
12. Name William Sands
13. Birthplace Hagerstown, Md.
MOTHER
14. Maiden name Dolly Cambell
15. Birthplace Hagerstown, Md.

16. Informant Mrs. Cora E. Sigman
Address St. Michaels, Md.

17. Cremation Date thereof Oct 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore, Md.

18. Funeral director Newnam & Harrison
Address St. Michaels, Md.

19. Oct 17, 1947 Mrs. Ruth H. Duh
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 October 19 47 at 11:50 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 May 19 46 to 16 Oct. 19 47
and that I last saw him alive on 16 October 19 47

Immediate cause of death Cardiac failure
Due to Chronic Asthma
DURATION 2 yrs
3 yrs

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Herbert Morrison
St. Michaels, Md. M. D. or other
Address St. Michaels, Md. Date signed 17 Oct 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 18 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09383

Reg. Dist. No. 29

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels,
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

George A. Sharp

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Nettie K. Sharp
 6. (c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) April 22, 1874
 8. AGE: Years 73 Months 6 Days 1 If less than one day
 hrs. min.

9. Birthplace Williamstown, West Virginia.
 (Town, county, and state)
 10. Usual occupation Retired Standard Oil
 11. Industry or business

FATHER
 12. Name John D. Sharp
 13. Birthplace St. Marys, West Virginia.
 MOTHER
 14. Maiden name Caroline McKinney
 15. Birthplace Williamstown, West Va.

16. Informant Dr. F. B. Shinn
 Address St. Michaels, Maryland.
 17. Burial Date thereof Oct 25, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Olivet Cemetery
 Location St. Michaels, Md.

18. Funeral director Henry Harrison
 Address St. Michaels Md
 19. Oct 25 19 47 Mrs. Robt. B. Seft
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Oct 19 47 at 5.30 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Oct 19 42 to 23 Oct 19 47
 and that I last saw him alive on 16 Oct 19 47
 Immediate cause of death Cardiac failure
 DURATION

Due to Coronary occlusion
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Robert Harrison M.D.
 Address Cuba Maryland Date signed 27 Oct 47
 M. D. or other

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

09384

1. PLACE OF DEATH:

County EssexCity or town Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 38 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Irma Louise Shreve

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Thomas Lee Shreve

7. Birth date of deceased (mo., day, yr.)

April 30, 1866

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

8155

hrs.

min.

9. Birthplace

Uniontown, Conn., Maryland
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

FATHER

12. Name

Henry Clay Shreve

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary P. Shreve

15. Birthplace

Md.

16. Informant

John P. Shreve
Address Easton, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

October 5, 1947
(month) (day) (year)

Cemetery or crematory

Uniontown, Maryland

Location

Uniontown, Md.

18. Funeral director

Robert Clark

Address

Easton, Md.

19.

(Date rec'd by registrar)

19. 47N.H. Nevin
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Essex

City or town

Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 5

19.

47

at

4

hr.

45

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

47

to

19.

47

at

10/5/47

19.

47

at

10/5/47

19.

47

and that I last saw her alive on

19.

47

at

10/5/47

19.

47

at

10/5/47

19.

47

Immediate cause of death

apoplexy

DURATION

2 hrs

Due to

arterial hypertensionSeveral yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

Dr. Cox

M. D. or other

Address

Easton, Md.Date signed 10/7/47

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OCT 18 1947
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